Medical Jurisprudence

Behavioral Sciences Term
St. Georges University
School of Medicine

Visiting Professor
Thaddeus Pope, JD, PhD

Segment 8 of 8

Death & Dying

Objectives

1. What is decision making capacity
2. What is an advance directive
3. Understand a patient's right to refuse life-saving treatment

3. What are the 3 types of substitute decision makers
4. Understand the difference between the 2 SDM decision making standards

5. Appreciate the difference between active and passive means of hastening death
6. Identify “passive” mechanisms for hastening death
7. Identify “active” mechanisms for hastening death

8. What is the legal standard for determining death
9. What are treatment duties after death

Death

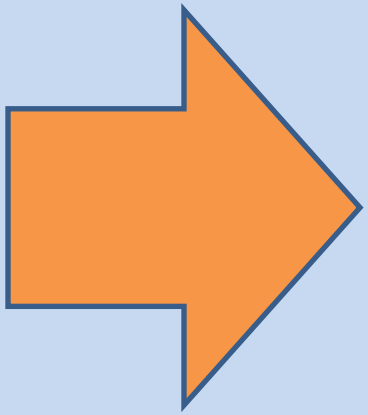
An individual . . . . . **is dead** . . .
who has sustained ***either***

(1) irreversible cessation of circulatory and respiratory functions, ***or***

(2) irreversible cessation of all functions of the entire brain

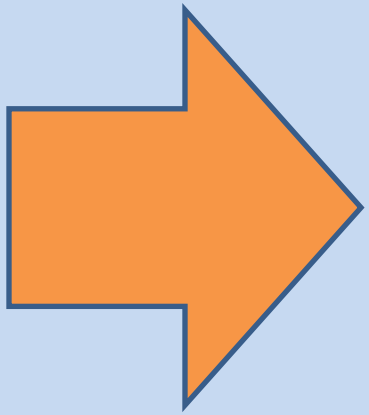
Consent **not** required to stop LSMT

Dead



Not a patient

Not a patient



No duty to treat


OFF

Annals of Internal Medicine

American College of Physicians Ethics Manual

Sixth Edition

Lois Snyder, JD, for the American College of Physicians Ethics, Professionalism, and Human Rights Committee*

"After a patient . . . brain dead . . . medical support should be discontinued."

Guidelines for Physicians: Forgoing Life-Sustaining Treatment for Adult Patients

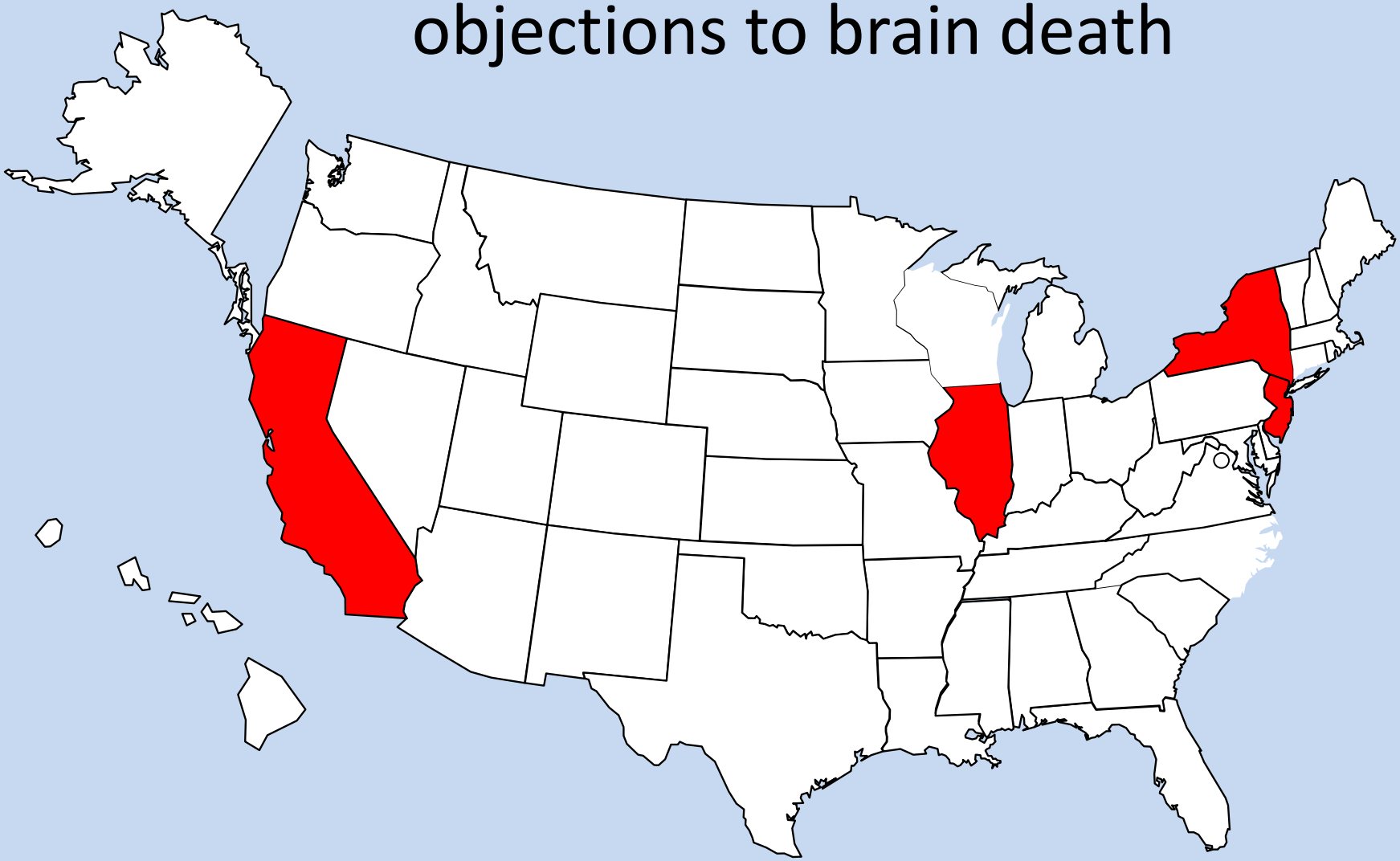
Joint Committee on Biomedical Ethics
of the
Los Angeles County Medical Association
and
Los Angeles County Bar Association

Approved by the Los Angeles County Medical Association February 15, 2006
Approved by the Los Angeles County Bar Association March 22, 2006

"Once death has been pronounced, all medical interventions should be withdrawn."

The rule almost everywhere

Duty to accommodate religious objections to brain death



Right to refuse

"The logical corollary of the doctrine of informed consent is that the patient generally possesses the **right not to consent,** that is, to refuse treatment."

- *Cruzan v. Missouri DOH* (1990)

Patient may refuse treatment **even** if life-saving

Ventilator

CANH (= med Tx)

Dialysis

CPR

Antibiotics

Dyspnea

Pain

Paralysis

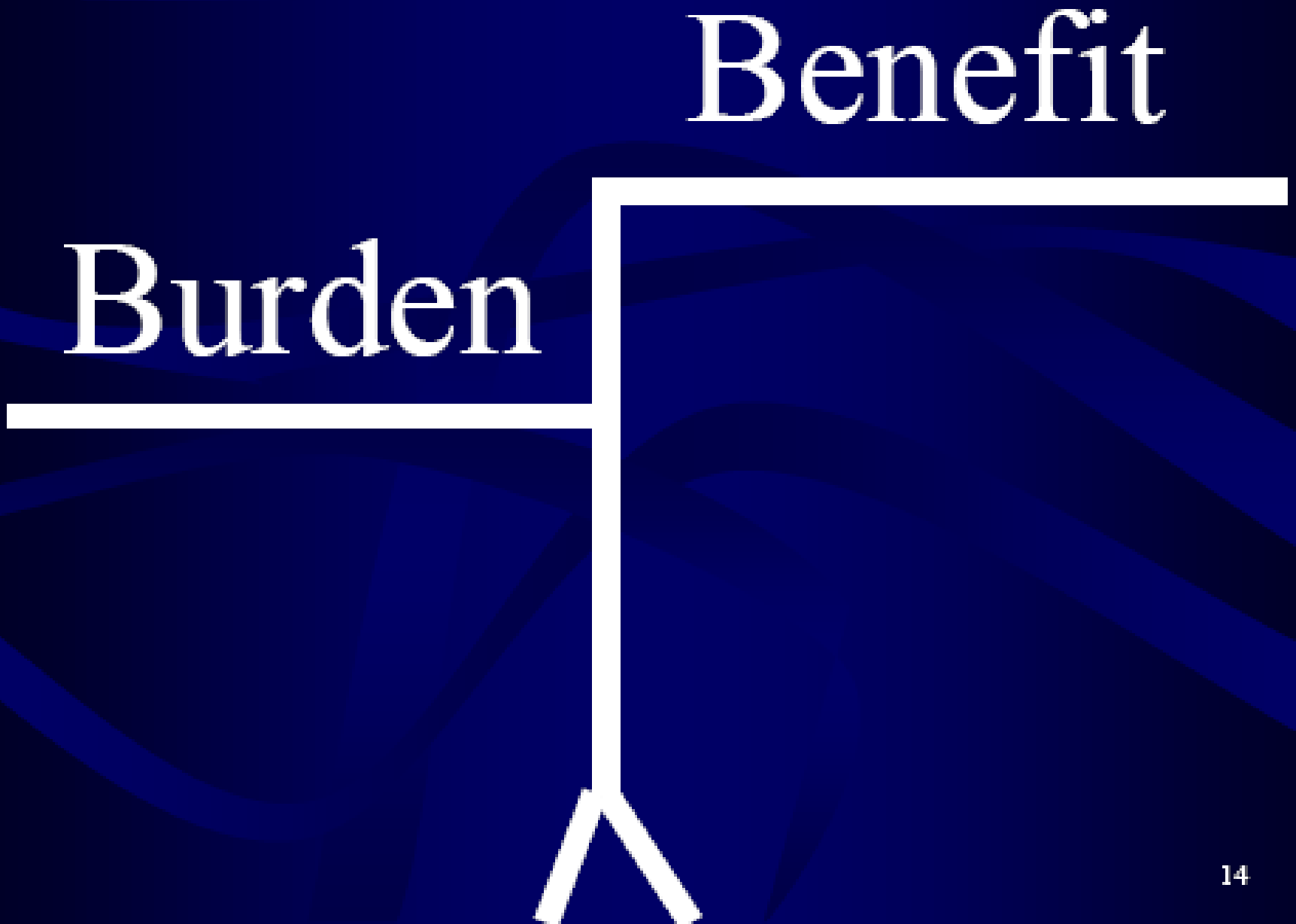
Nausea

Loss of control

Anxiety

Delirium

Hopelessness


Benefit
Burden

self-defined QOL

Pt **own** assessment

Pt **own** values

Pt **own** preferences

Who is to say if amount life left to a patient is worth living

Person herself

State interests

Preservation life

Prevent suicide

Protect 3rd parties

Integrity med profession

Almost always **outweighed** by patient's right to self-determination

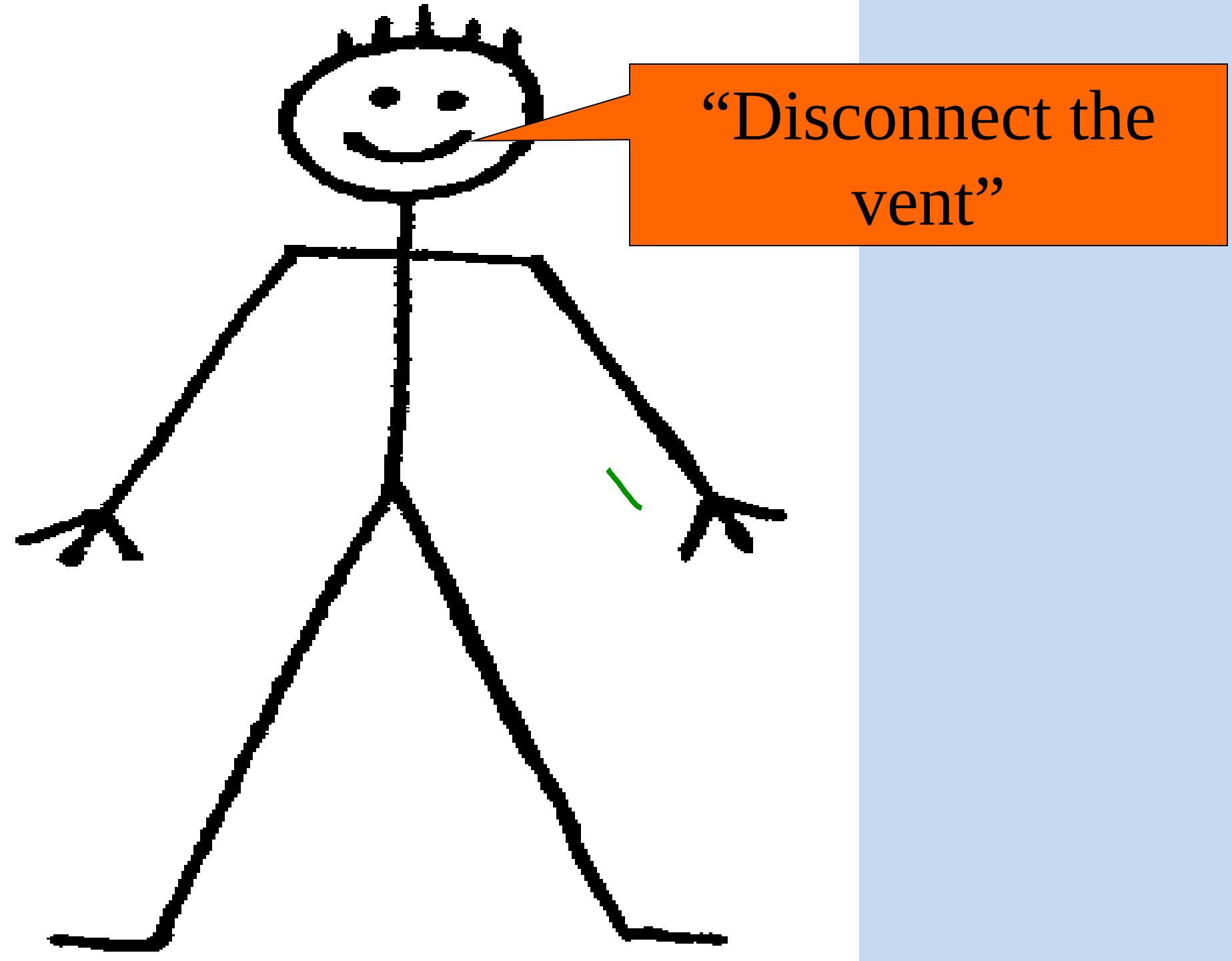
Palliative Care

Prevent and relieve suffering

- physical
- psychosocial
- spiritual

Easier situation

Contemporaneous patient refusal


“Disconnect the vent”

Tougher situation

When patient now lacks capacity

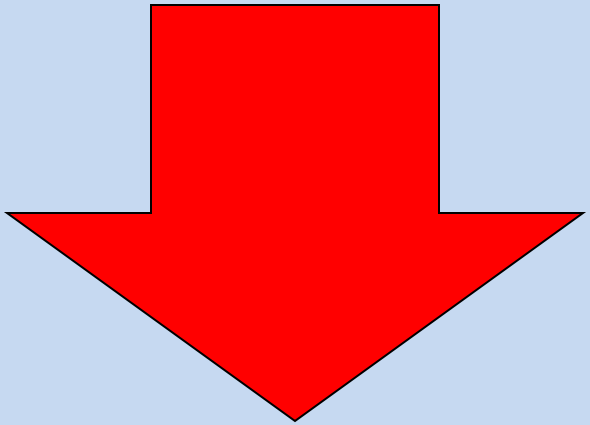
Many patients lack capacity at the end of life

DNR only means “no CPR”

It does not mean “do not treat”

Prospective Autonomy

Patient is competent + patient has capacity to make the decision at hand



Patient decides

Patient not lose right of self-determination when lose capacity

- Who decides
- What standards

Advance directive

Substitute decision maker

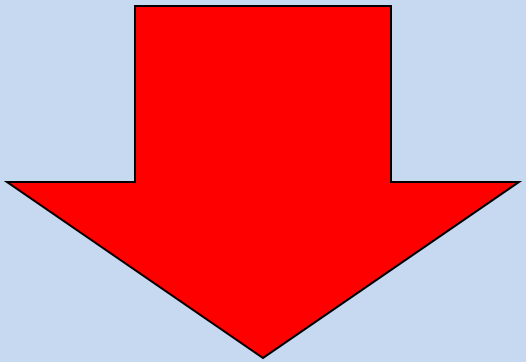
Advance Directive


Living Will

Patient lacks capacity but left instructions while did

Instructions available

Instructions apply to present circumstances



Follow instructions (self-executing)

PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

Views on End-of-Life Medical Treatments

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

18-29	15%
30-49	33%
50-64	38%
65-74	61%
75+	58%

SDM **bound** by instructions in advance directive

SDM **lack authority** to contravene patient's instructions (or known preferences or best interests)

Limits of Advance Directives

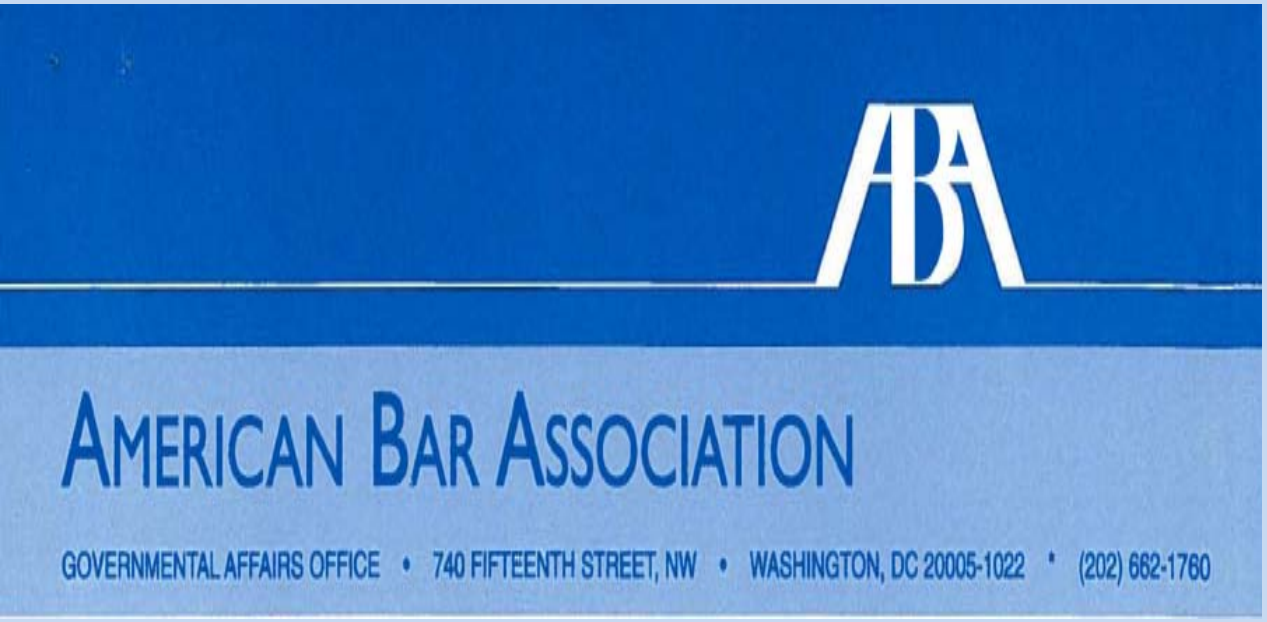
Not completed

Not found

Not informed

Not clear

Not completed


ABA
AMERICAN BAR ASSOCIATION
GOVERNMENTAL AFFAIRS OFFICE • 740 FIFTEENTH STREET, NW • WASHINGTON, DC 20005-1022 • (202) 662-1760

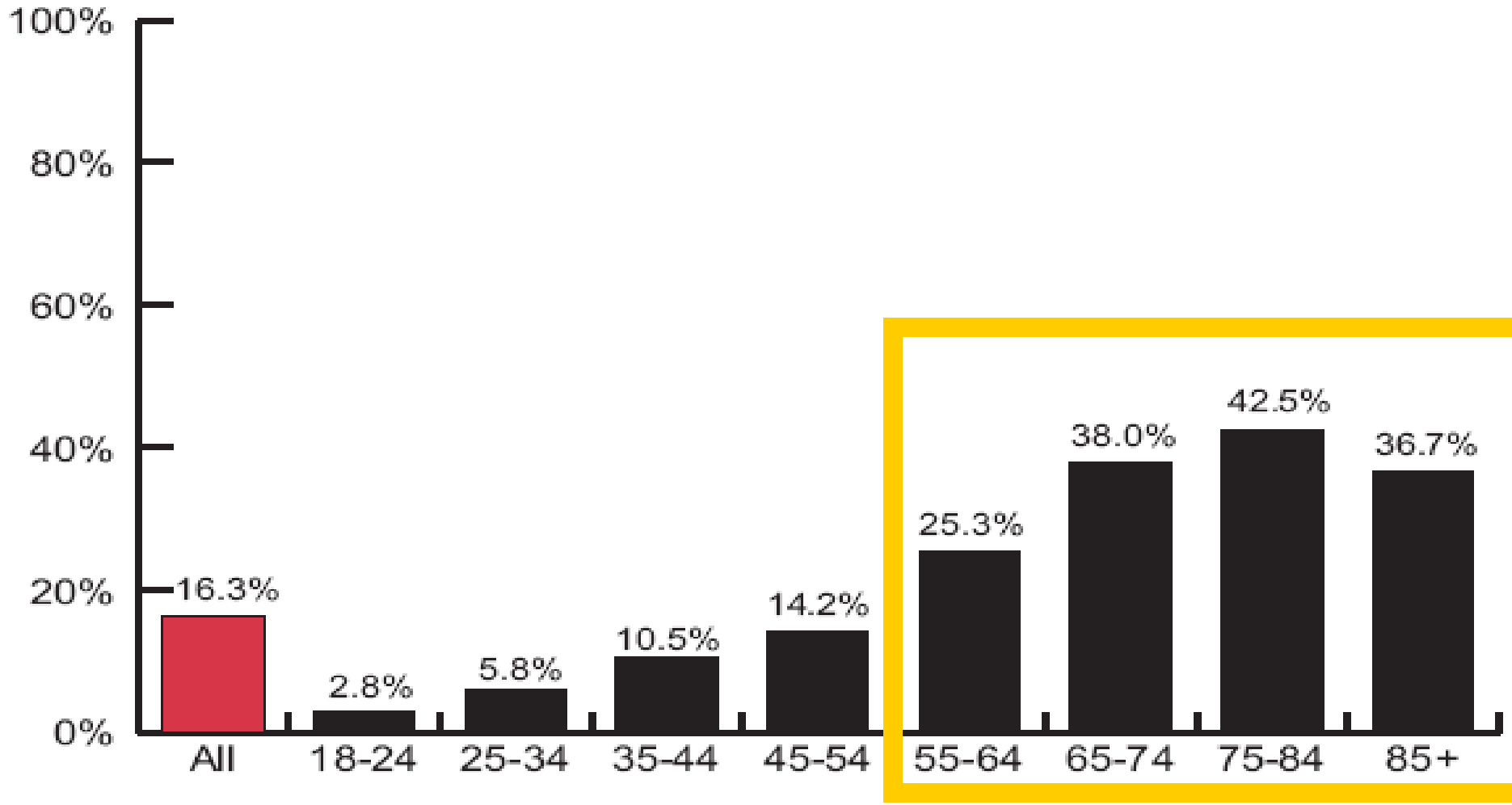
30%


AARP

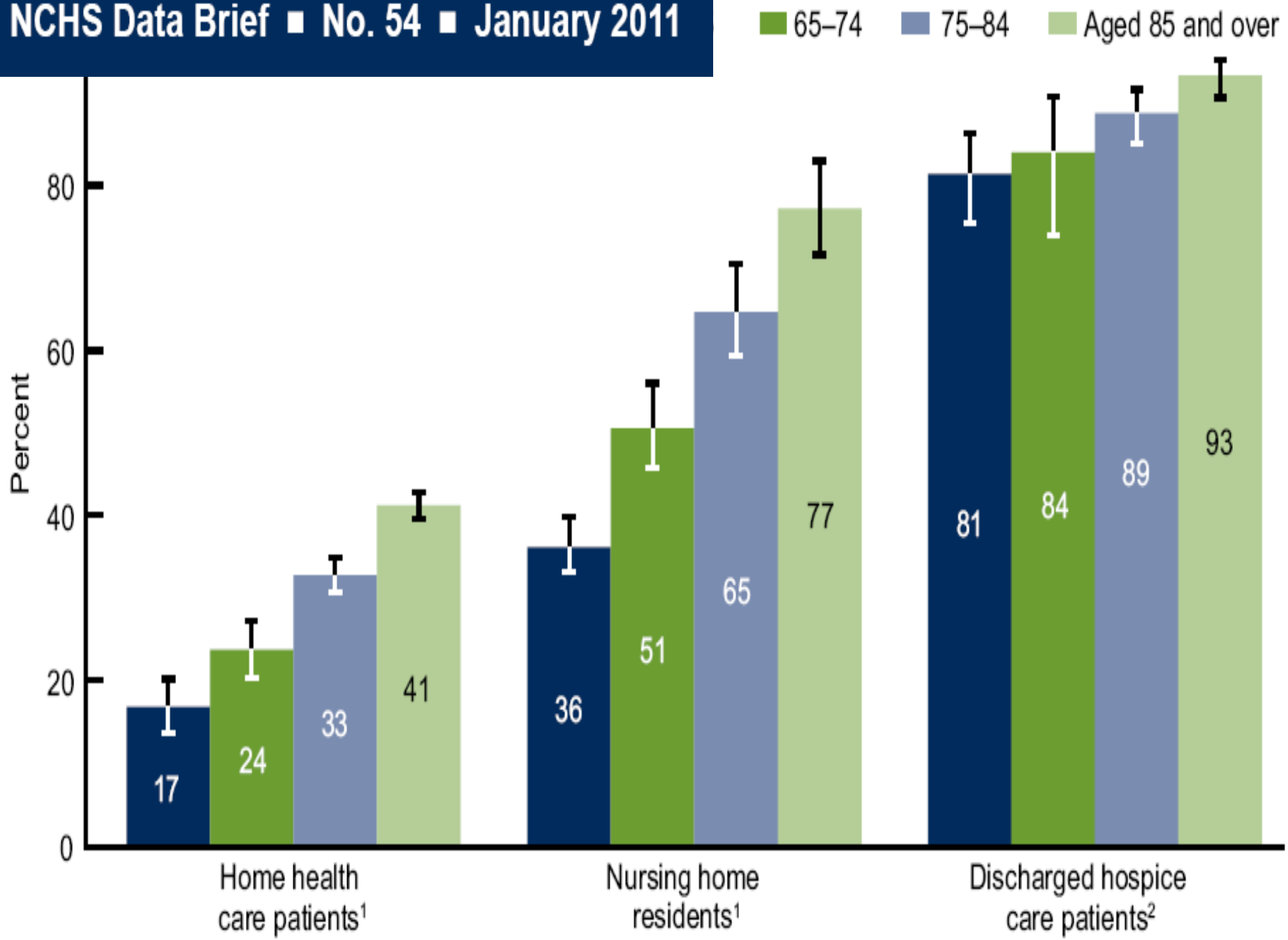
28%

Figure 1: Few Adults in New Jersey Report Having an Advance Directive

Older residents are most likely to have a directive



Source: Rutgers Center for State Health Policy, New Jersey Family Health Survey, 2001


65–74
75–84
Aged 85 and over
Percent
0
20
40
60
80
17
24
33
41
36
51
65
77
81
84
89
93
Home health care patients[1]
Nursing home residents[1]
Discharged hospice care patients[2]

Not found

BANK OF MONTREAL

DUPONT STREET & SYMINGTON AVENUE BRANCH
1502-1504 DUPONT STREET
TORONTO, ONT.

NO.

Mar. 29 1966

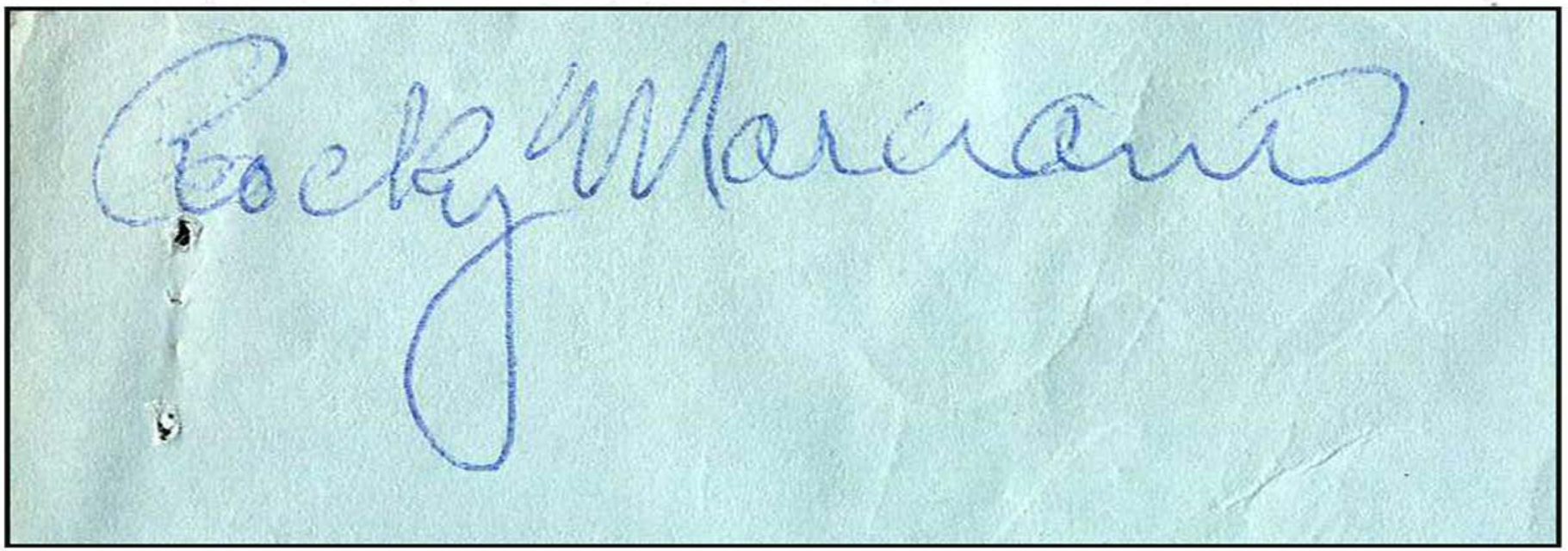
PAY TO THE ORDER OF Rocky Marciano — $ 1300 00/xx

— Thirteen Hundred — 00/100 DOLLARS

Pay to A & S Enterprises
Paid in Full

APOLLO PROMOTIONS LIMITED

⑆03952⑈001⑆ ⑆008⑈247⑈



65-76% of physicians whose patients **have** advance directives do not know they **exist**

U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Individuals fail to make & distribute copies

- Primary agent
- Alternate agents
- Family members
- PCP
- Specialists
- Attorney
- Clergy
- Online registry

Not informed

Enough

The Failure of the Living Will

by Angela Fagerlin and Carl E. Schneider

In pursuit of the dream that patients' exercise of autonomy could extend beyond their span of competence, living wills have passed from controversy to conventional wisdom, to widely promoted policy. But the policy has not produced results, and should be abandoned.

Annals of Internal Medicine

PERSPECTIVE

Controlling Death: The False Promise of Advance Directives

Henry S. Perkins, MD

Advance directives promise patients a say in their future care but actually have had little effect. Many experts blame problems with completion and implementation, but the advance directive concept itself may be fundamentally flawed. Advance directives simply presuppose more control over future care than is realistic. Medical crises cannot be predicted in detail, making most prior instructions difficult to adapt, irrelevant, or even misleading. Furthermore, many provider either do not know patients' wishes or do not pursue those wishes effectively. Thus, unexpected problems arise often to defeat advance directives, as the case in this paper illustrates. Because advance directives offer only limited benefit, advance care planning should emphasize not the completion of directives but the emotional preparation of patients and families for future crises. The existentialist Albert Camus might suggest that physicians should warn patients and families that momentous, unforeseeable decisions lie ahead. Then, when the crisis hits, physicians should provide guidance; should help make decisions despite the inevitable uncertainties; should share responsibility for those decisions; and, above all, should courageously see patients and families through the fearsome experience of dying.

Ann Intern Med. 2007;147:51-57.

www.annals.org

For author affiliation, see end of text.

Not

clear

if ____,

then ____

Trigger terms vague

"Reasonable expectation of recovery"

75% 51%

25% 10%

Plus: prognosis uncertain

Preferences vague

"No ventilator"

Ever

Even if temporary

SITUATION A

If I am in a coma or a persistent vegetative state and, in the opinion of my physician and two consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my goals and specific wishes — if medically reasonable — for this and any additional illness would be:

Please check appropriate boxes:

	I want	I want treatment tried. If no clear improvement, stop.	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).		*Not applicable*		
2. Major surgery (for example, removing the gallbladder or part of the colon).		*Not applicable*		
3. Mechanical breathing (respiration by machine, through a tube in the throat).				
4. Dialysis (cleaning the blood by machine or by fluid passed through the belly).				
5. Blood transfusions or blood products.		*Not applicable*		
6. Artificial nutrition and hydration (given through a tube in a vein or in the stomach).				
7. Simple diagnostic tests (for example, blood tests or x-rays).		*Not applicable*		
8. Antibiotics (drugs used to fight infection).		*Not applicable*		
9. Pain medications, even if they dull consciousness and indirectly shorten my life.		*Not applicable*		

	Yes. I would want to have life-sustaining treatments.	It would depend on the circumstances.	**No.** I would not want to have life-sustaining treatments.
If I am unconscious, in a coma, or in a persistent vegetative state and there is little or no chance of recovery	Initials	Initials	Initials
If I have permanent severe brain damage (for example, severe dementia) that makes me unable to recognize my family or friends	Initials	Initials	Initials
If I have a permanent condition that makes me completely dependent on others for my daily needs (for example, eating, bathing, toileting)	Initials	Initials	Initials
If I am confined to bed and need a breathing machine for the rest of my life	Initials	Initials	Initials
If I have pain or other severe symptoms that cannot be relieved	Initials	Initials	Initials
If I have a condition that will cause me to die very soon, even with life-sustaining treatments	Initials	Initials	Initials

More technology is the **default**

Patient must **opt out**

POLST

POLST

Provider

Order

Life

Sustaining

Treatment

POLST

Physician

Order

Life

Sustaining

Treatment

POST Physician Order for Scope of Treatment

MOST Medical . . .

MOLST Medical . . .

COLST Clinician . . .

Thaddeus Mason Pope and Melinda Hexum, "Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment," *The Journal of Clinical Ethics* 23, no. 4 (Winter 2012): 353-76.

Law

Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment

Thaddeus Mason Pope and Melinda Hexum

ABSTRACT

This issue's "Legal Briefing" column covers recent legal developments involving POLST (physician orders for life-sustaining treatment.)' POLST has been the subject of recent articles in *JCE*.[2] It has been the subject of major policy reports[3] and a recent *New York Times* editorial.[4] And POLST has been the subject of significant legislative, regulatory, and policy attention over the past several months. These developments and a survey of the current landscape are usefully grouped into the following 14 categories:

1. Terminology
2. Purpose, function, and success
3. Status in the states
4. Four legal routes of implementation
5. Which professionals can authorize POLST?
6. Is the patient's signature required?
7. Can surrogates consent to for incapacitated patients?
8. If a POLST conflicts with an advance directive, which prevails?
9. Is offering POLST mandatory?
10. What are the duties of healthcare providers?
11. What is the role of electronic registries?
12. What is the role of the federal government?
13. International adoption
14. Court cases

1. TERMINOLOGY

While the POLST paradigm is established or developing in almost every U.S. state, it goes by at least 14 different names.[5] For the sake of clarity, this article will use the acronym POLST, as it is the acronym used by most states. Even among these states, POLST stands for three different terms. In most of the states, POLST stands for physician orders for life-sustaining treatment.[6] In Minnesota and Montana, it stands for provider orders for life-sustaining treatment.[7] In Pennsylvania, POLST stands for Pennsylvania orders for life-sustaining treatment.[8]

The remaining states use 11 additional ac-

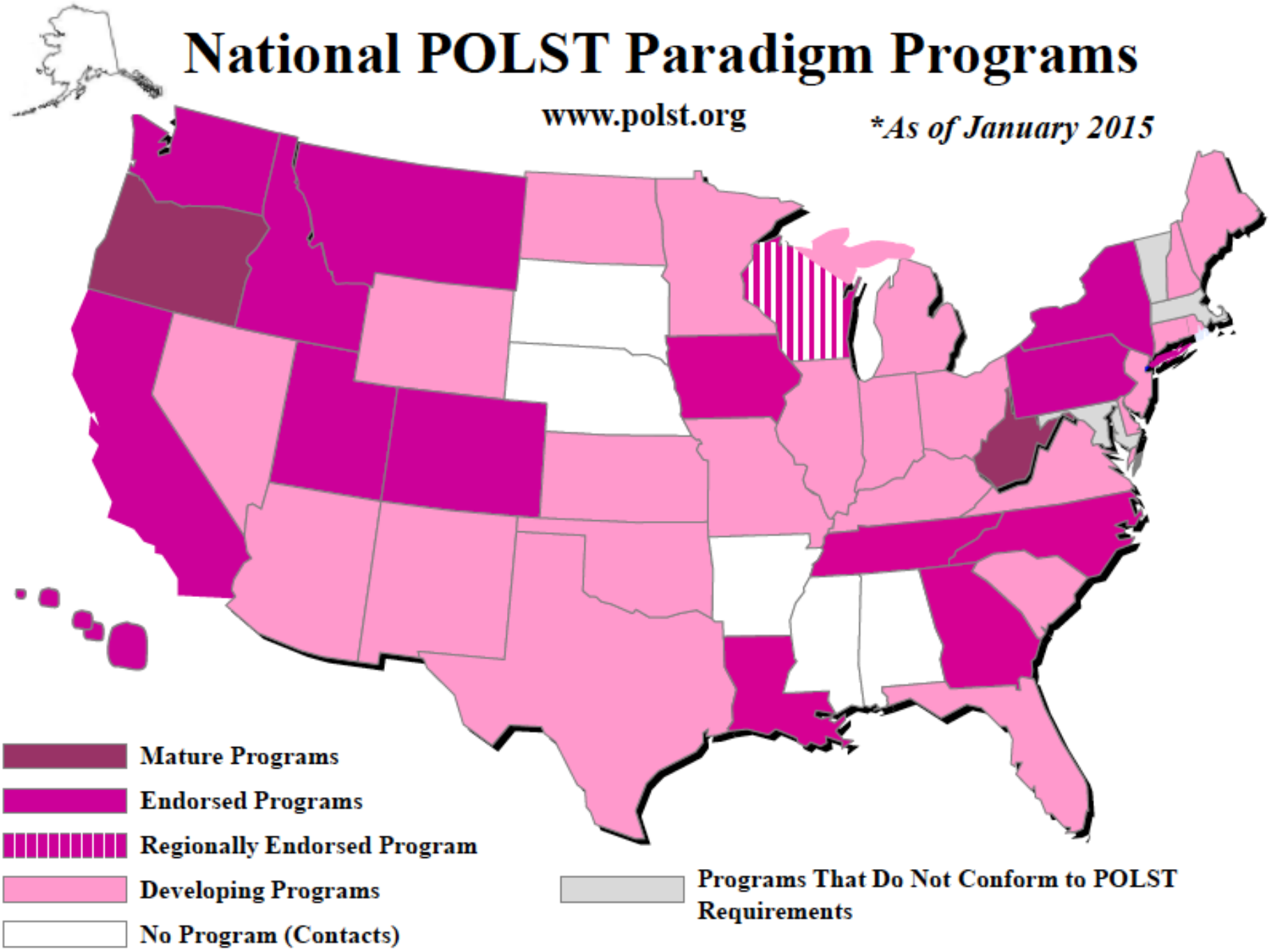
Many acronyms

Same concept

National POLST Paradigm Programs

www.polst.org

**As of January 2015*



What is

POLST

POLST: Provider Orders for Life Sustaining Treatment POLST

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

PROVIDER ORDERS FOR
LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, THEN contact the patient's provider. This is a provider order sheet based on the patient's medical condition and wishes. POLST translates an advance directive into provider orders. Any section not completed implies the most aggressive treatment for that section. Patients should always be treated with dignity and respect.

Last Name

First/Middle Initial

Date of Birth

Primary Care Provider/Phone

A Check One

CARDIOPULMONARY RESUSCITATION (CPR):

Patient has no pulse and is not breathing.

☐ **CPR/ATTEMPT RESUSCITATION**

☐ **DNR/DO NOT ATTEMPT RESUSCITATION** (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

B Check One Goal

GOALS OF TREATMENT:

Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

Additional Orders (e.g. dialysis, etc.)

☐ **COMFORT CARE** — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.

Check all that apply:

- ☐ In an emergency, call _____ (e.g. hospice)
- ☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
- ☐ If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS** — Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)

Check one:

- ☐ Do not intubate
- ☐ Trial of intubation (e.g._____days) or other instructions: _____

☐ **PROVIDE LIFE SUSTAINING TREATMENT**

Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)

C Check All That Apply

INTERVENTIONS AND TREATMENT

ANTIBIOTICS *(check one)*:

- ☐ No Antibiotics (Use other methods to relieve symptoms whenever possible.)
- ☐ Oral Antibiotics Only (No IV/IM)
- ☐ Use IV/IM Antibiotic Treatment

NUTRITION/HYDRATION *(check all that apply)*:

Additional Orders:

- ☑ Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)
- ☐ Tube feeding through mouth or nose
- ☐ Tube feeding directly into GI tract
- ☐ IV fluid administration
- ☐ Other: _____

Provider Name (MD/DO/APRN/PA when delegated, are acceptable)

Provider Signature

Date

FAXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID.

TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE "VOID" IN LARGE LETTERS.

POLST

A

Check One

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- ☐ Tube feeding directly into GI tract
- ☐ IV fluid administration
- ☐ Other: _____

Additional Orders:

_____

_____

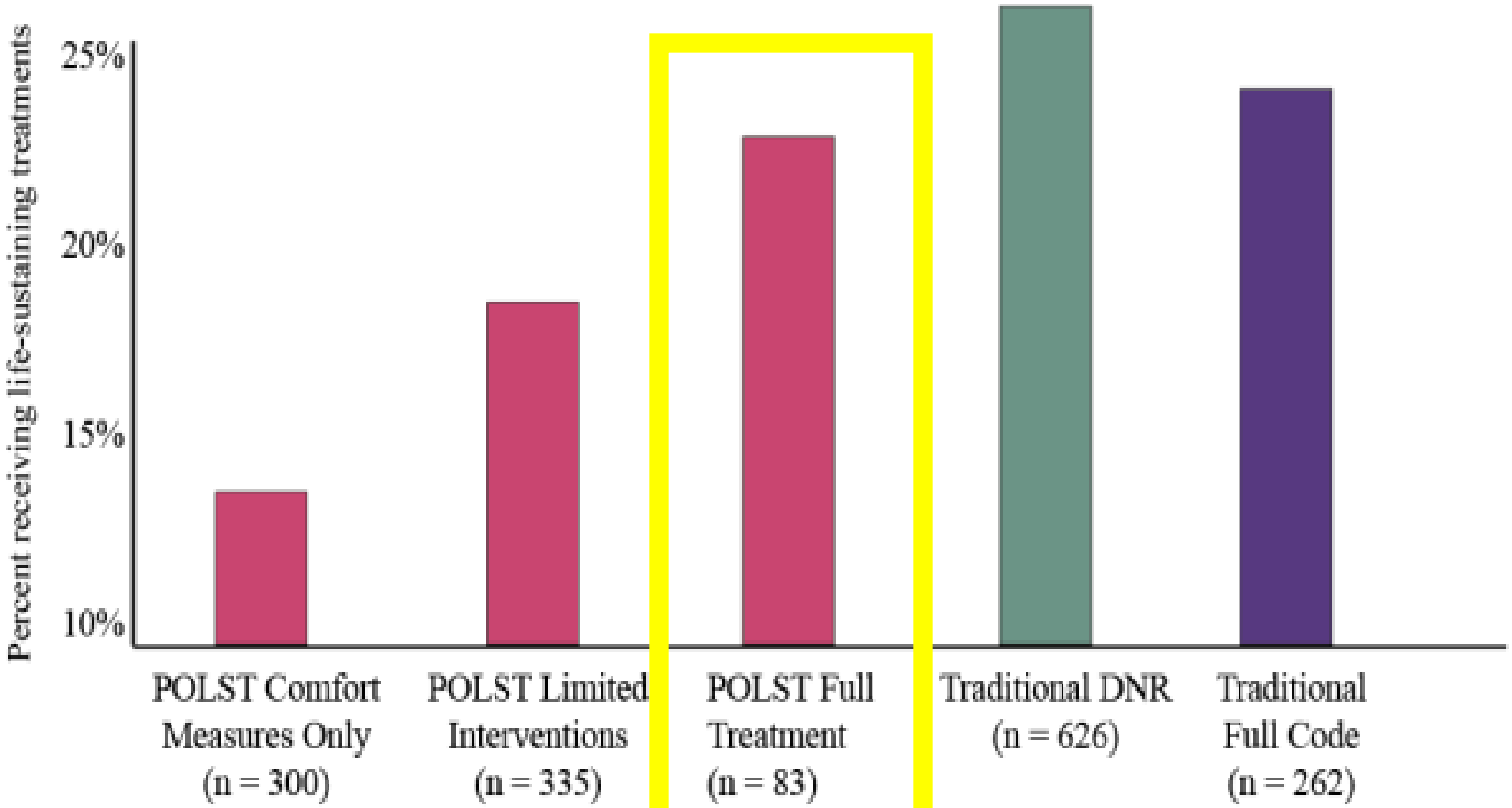
_____

_____

Order

for LST

Life-Sustaining Treatments Received (n = 1,606)*†

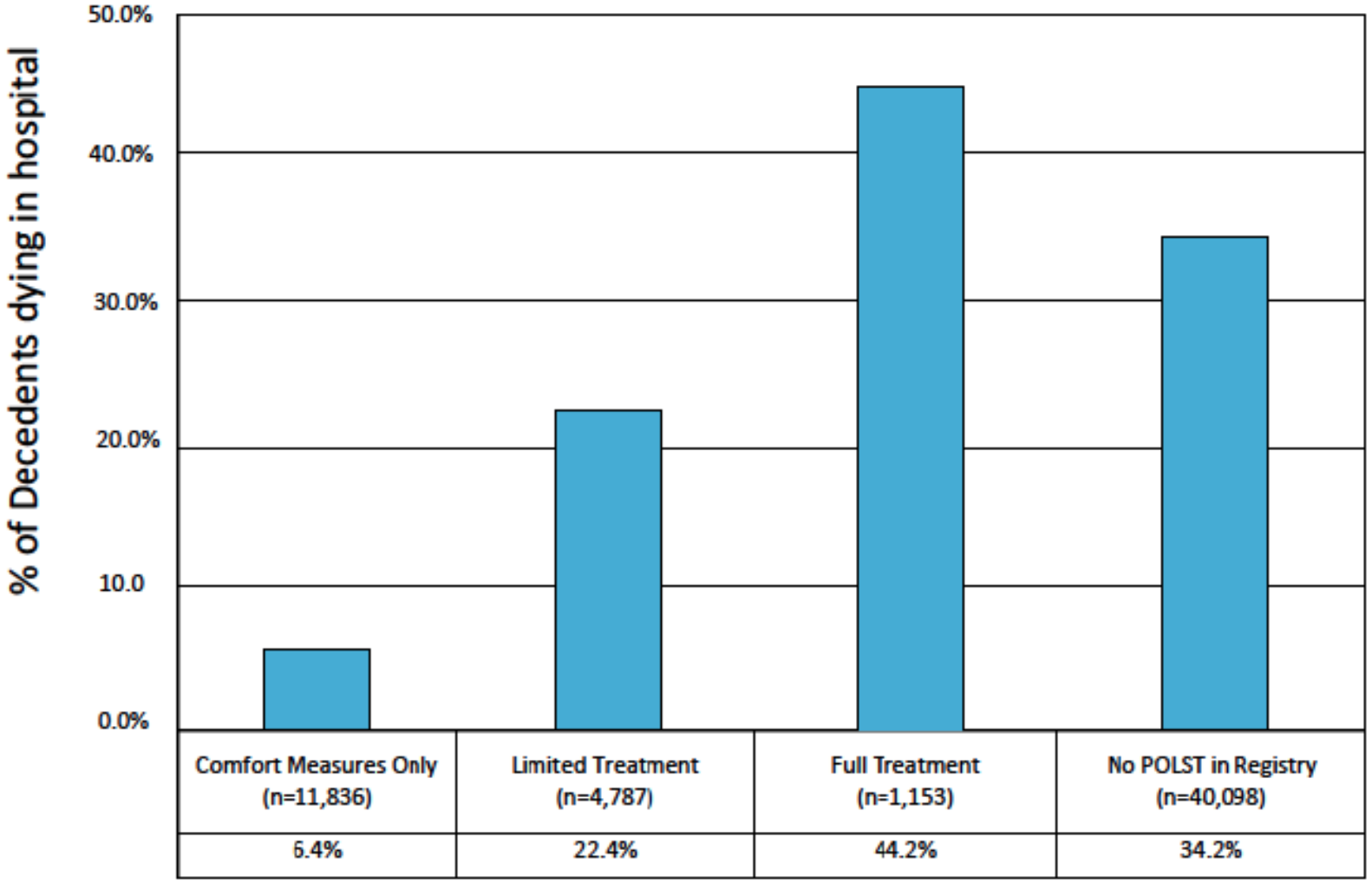


* Analyses performed with subset of residents having the same orders in place for at least 60 days. For residents with POLST forms, only those with orders for medical interventions (Section B) were included.

† Life-sustaining treatments in Section B included hospitalization/ED visits, IV fluids, dialysis, transfusion, surgery/invasive diagnostic tests, chemotherapy/ radiation, and intubation/ ventilator support.

JAGS 58: 1241-1248, 2010 . A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices versus the Physicians Orders for Life-Sustaining Treatment (POLST) Program.
Susan E. Hickman, PhD, Christine A. Nelson, PhD, RN, Nancy A Perrin, PhD, Alvin H Moss, MD, Bernard J Hammes, PhD, and Susan W. Tolle, MD.

Patient's preferences recorded as medical orders on a POLST Form and how those orders match with death in the hospital



JAGS: Fromme et al 2014 62: 1246-1251

For

whom

Terminal illness

Advanced chronic progressive illness

Frailty

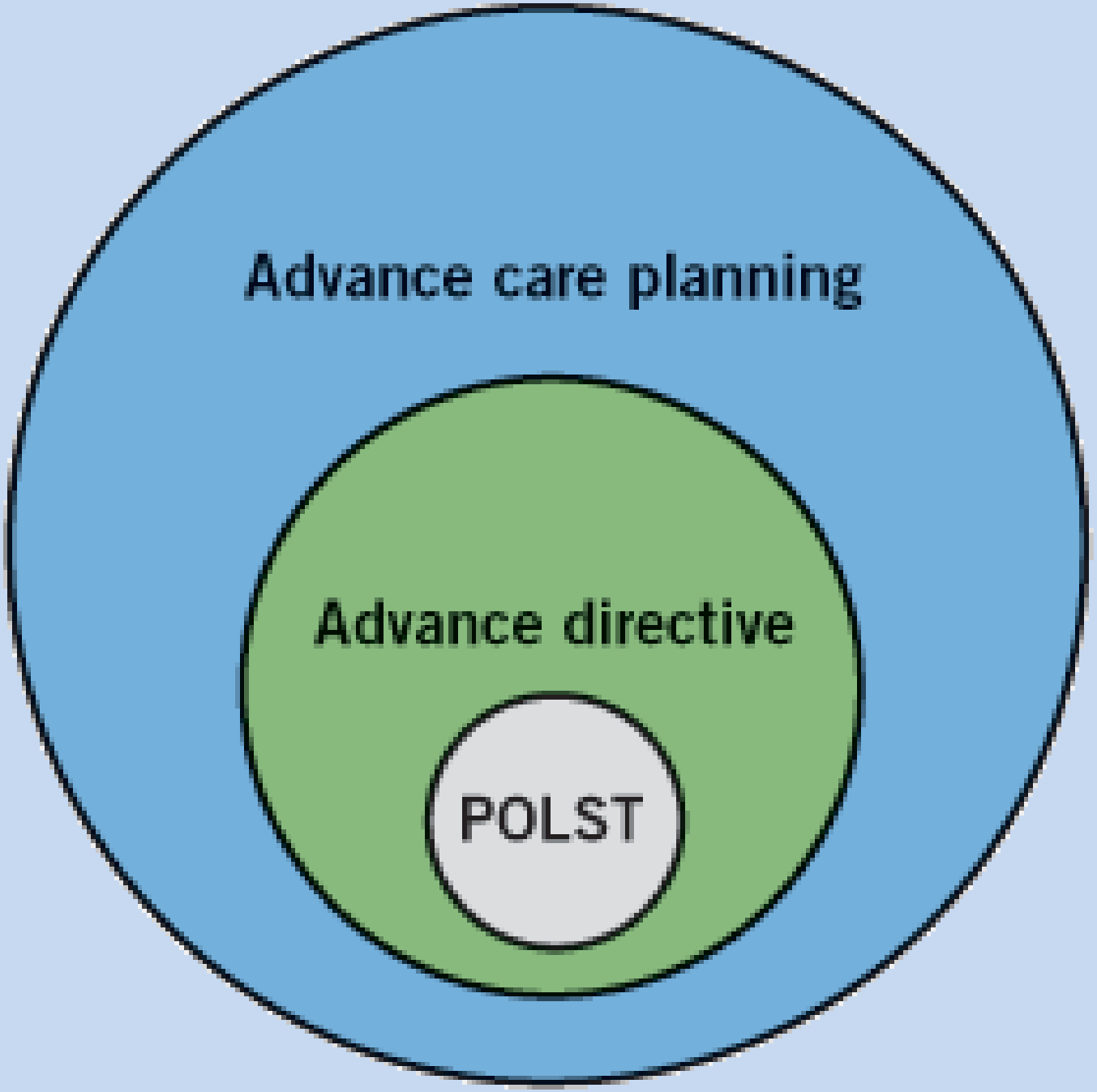
In last year of life

Others who want to define care

MOLST **supplements**

AD

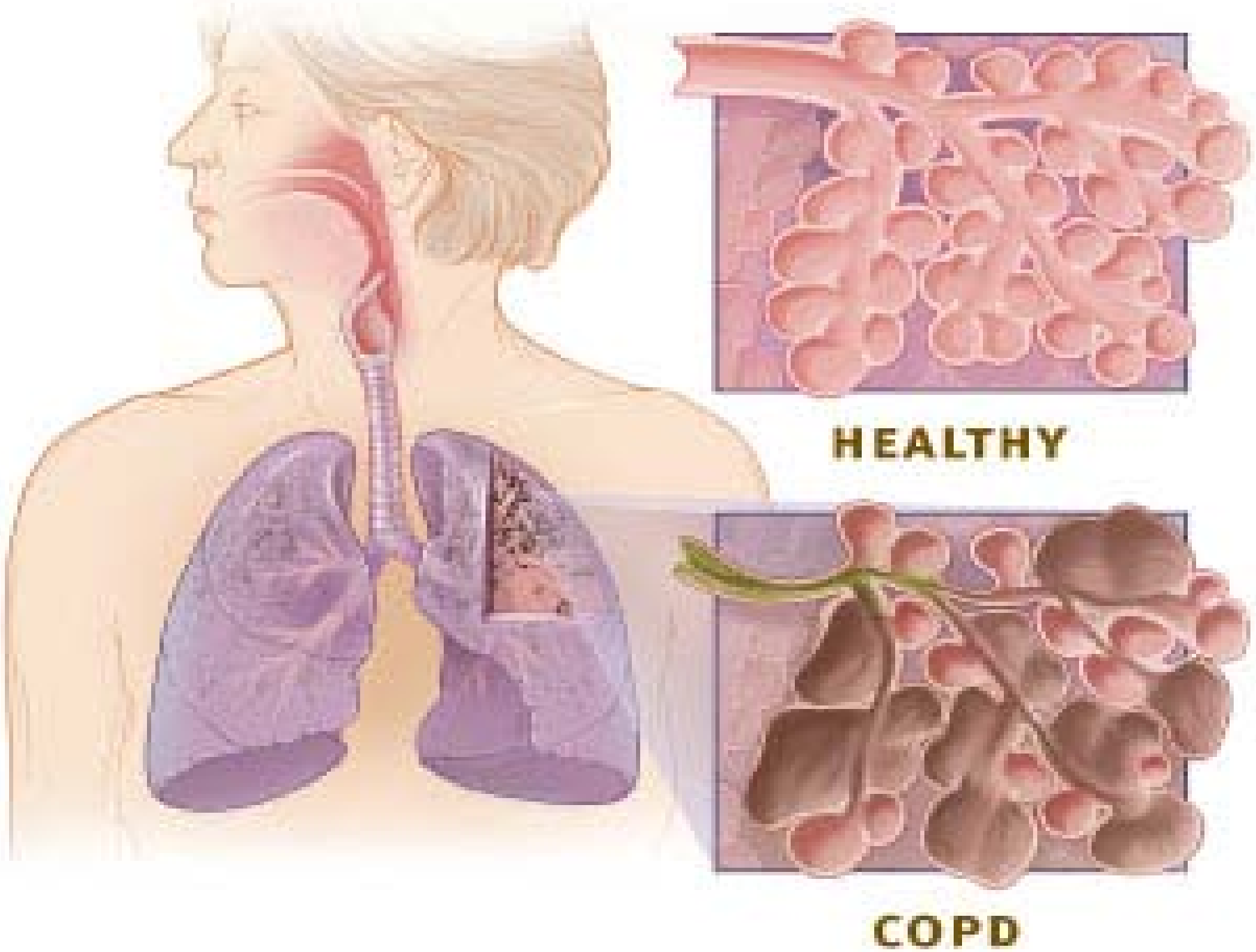
Does not replace


Advance care planning
Advance directive
POLST

Both

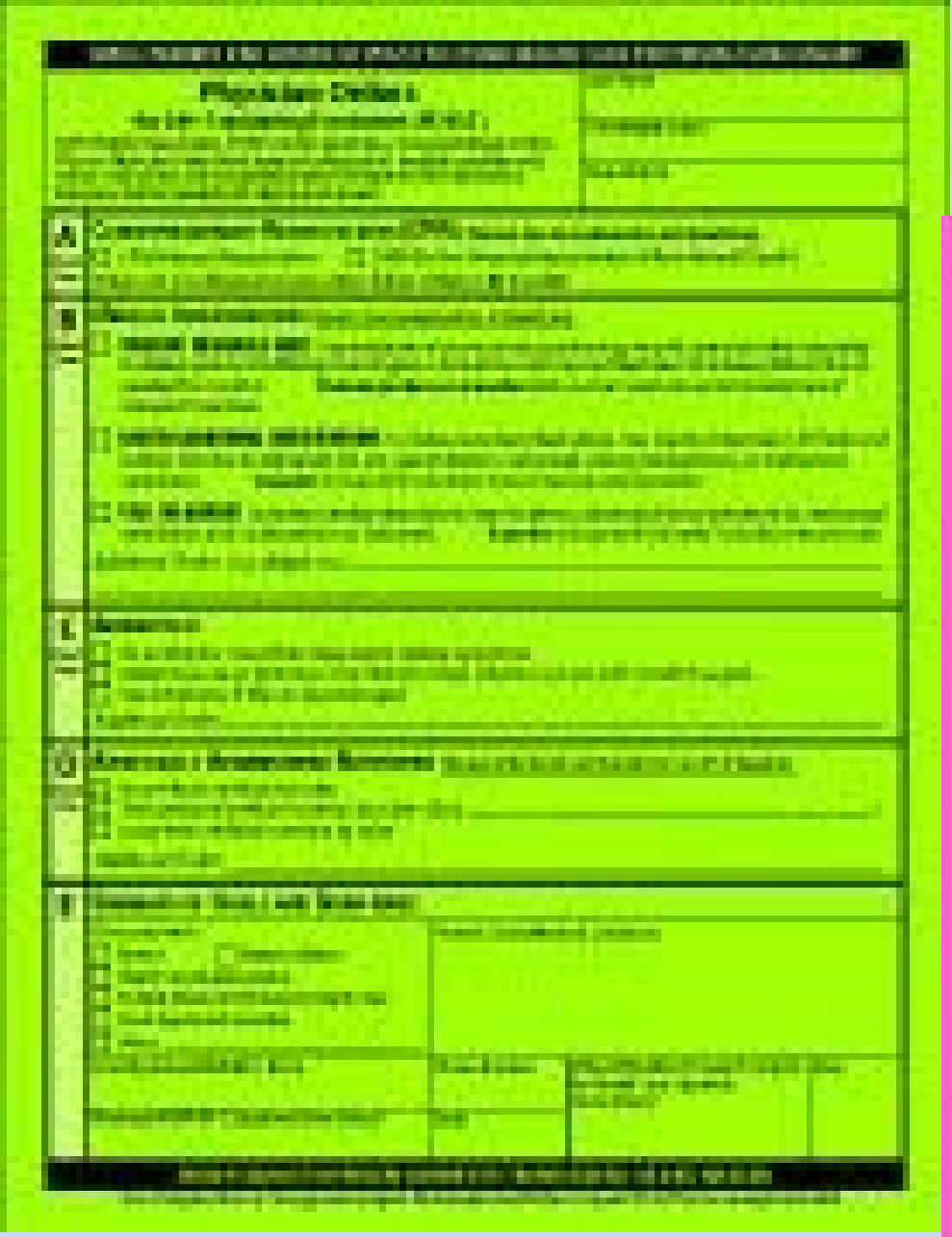
The present

Here & now


HEALTHY
COPD

MOLST benefits

1. Bright color



MOLST

Medical Orders for Life-Sustaining Treatment
Do Not Resuscitate (DNR) and
other Life-Sustaining Treatments (LST)

Section A

Section B

Section C

Section D

Original MOLST printed on **lilac** card stock

But a **copy** has the same force as original

2. Single page

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Additional Orders (e.g. dialysis, etc.)

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POLST

3. More informed

MEDICAL ORDERS for life-sustaining treatment (MOLST)

F

SIGNATURES: Preferences have been expressed to the health care provider whose signature is found below. This document reflects those preferences. If signed by a surrogate, preferences must reflect patient's wishes as best understood by the surrogate.

Discussed with:

☐ Patient ☐ Parent of Minor

☐ Legal Guardian ☐ Next-of-Kin

☐ Health Care Agent

PRINT – Physician/APN/PA Name Phone #

Physician/APN/PA Signature (mandatory) Date

Physician Co-Signature if PA Signs Above (mandatory) Date

_____

4. Immediately actionable

Provider

Order

Life

Sustaining

Treatment

No need to “**interpret**” advance directive

No need to “**translate**” into orders

5. Easy to follow

A

Check One

CARDIOPULMONARY RESUSCITATION (CPR):

Patient has no pulse and is not breathing.

☐ CPR/ATTEMPT RESUSCITATION

☐ DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

6. Better honored

Can follow

will follow

7. Portable

Home

LTC

Hospital

EMS

8. Updatable

MOLST does

not expire

MOLST can be revised or revoked at any time

Review with change in condition or location

Can be completed by **surrogate**, if patient lacks capacity

70% patient

30% surrogate

9. Proven Effective

POLST is Evidence Based

- Major academic research in 3 POLST states: strong evidence base of efficacy of POLST in ensuring preferences are elicited, documented, honored, w/ pain and symptom management equivalent to those without POLST order

Hickman et al. "A Comparison of Methods to Communicate Treatment Preferences: Traditional Practices versus the Physician Orders for Life-Sustaining Treatment Program" J Am Geriatr Soc 58:1241–1248, 2010.

Closes gap between what people **want** and what they **get**

Recap

Mostly well settled patient with capacity may refuse life-saving treatment **contemporaneously**

Mostly well settled patient without capacity may refuse life-saving treatment through **advance instructions**

Mostly well settled patient without capacity may refuse life-saving treatment through decision of **authorized SDM**

This is all “**passive**”

Refusing something (chemo, CPR, ventilator, CANH, antibiotics)

Contrast **active** means to hasten death

What is a medical futility dispute

"I'm afraid there's really very little I can do."

Surrogate driven over-treatment

Clinician	Surrogate
CMO	LSMT

Consent **always**

Assisted Suicide

Illegal everywhere

"Whoever intentionally . . . **assists** another in taking the other's own life may be sentenced to imprisonment for not more than 15 years . . . ."

Minn. Stat. 609.215

“aid in dying”

Physician prescribing medication to a mentally capacitated, terminally ill patient, which the patient may ingest to bring about a peaceful death”

1997

SCOTUS

No Constitutional right

Not a “fundamental” right

Not a violation of equal protection

“States are presently undertaking extensive and serious evaluation of physician assisted suicide . . . .”

“In such circumstances, the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the **laboratory of the States** . . .”

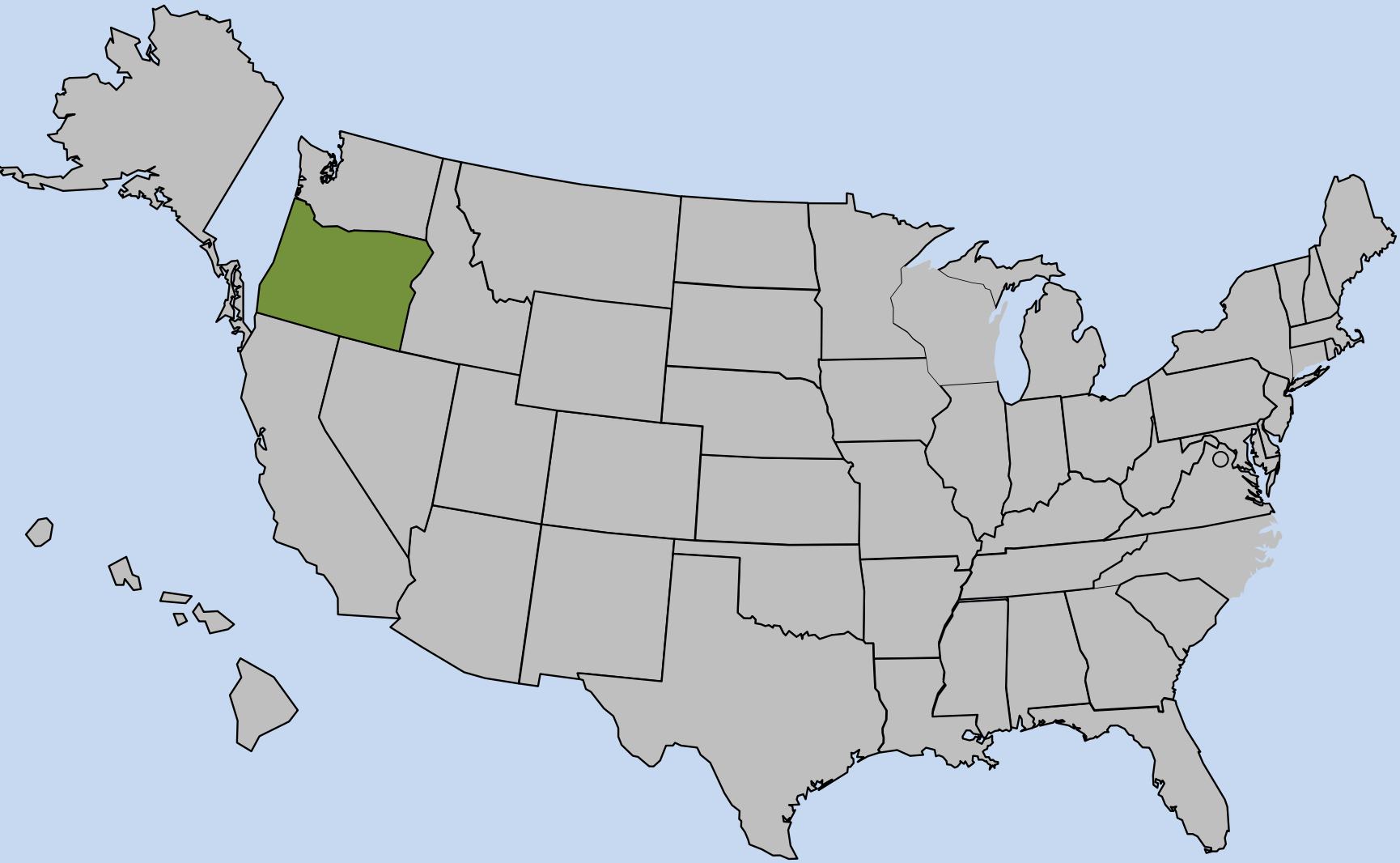
1994

Oregon

Ballot initiative

51%

In operation
1997 - ongoing



Who

Terminal illness (6 months)

Resident

18+

Capacity

How

Doc educates patient about all options –

- palliative care
- pain management
- hospice

Oral request

15 days

2nd oral request

Written request

48 hours

Doc writes prescription

Patient gets at pharmacy

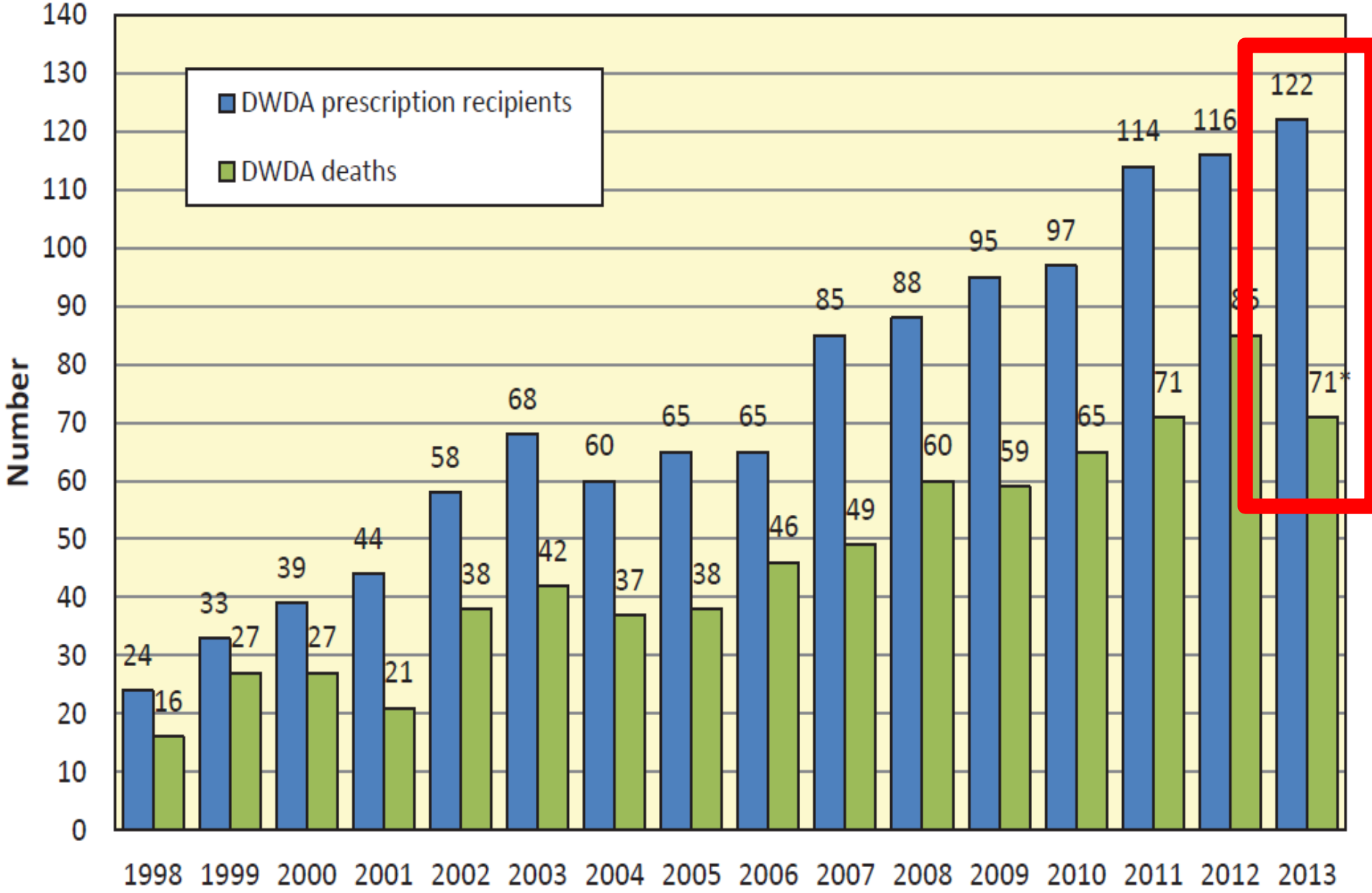
Must self ingest

Self ingest

Patient takes final overt act leading to death

If physician did it, that would be euthanasia & crime everywhere USA

Oregon DWDA Prescription Recipients and Deaths*, 1998-2013



97% white

98% health insurance

90% enrolled in hospice

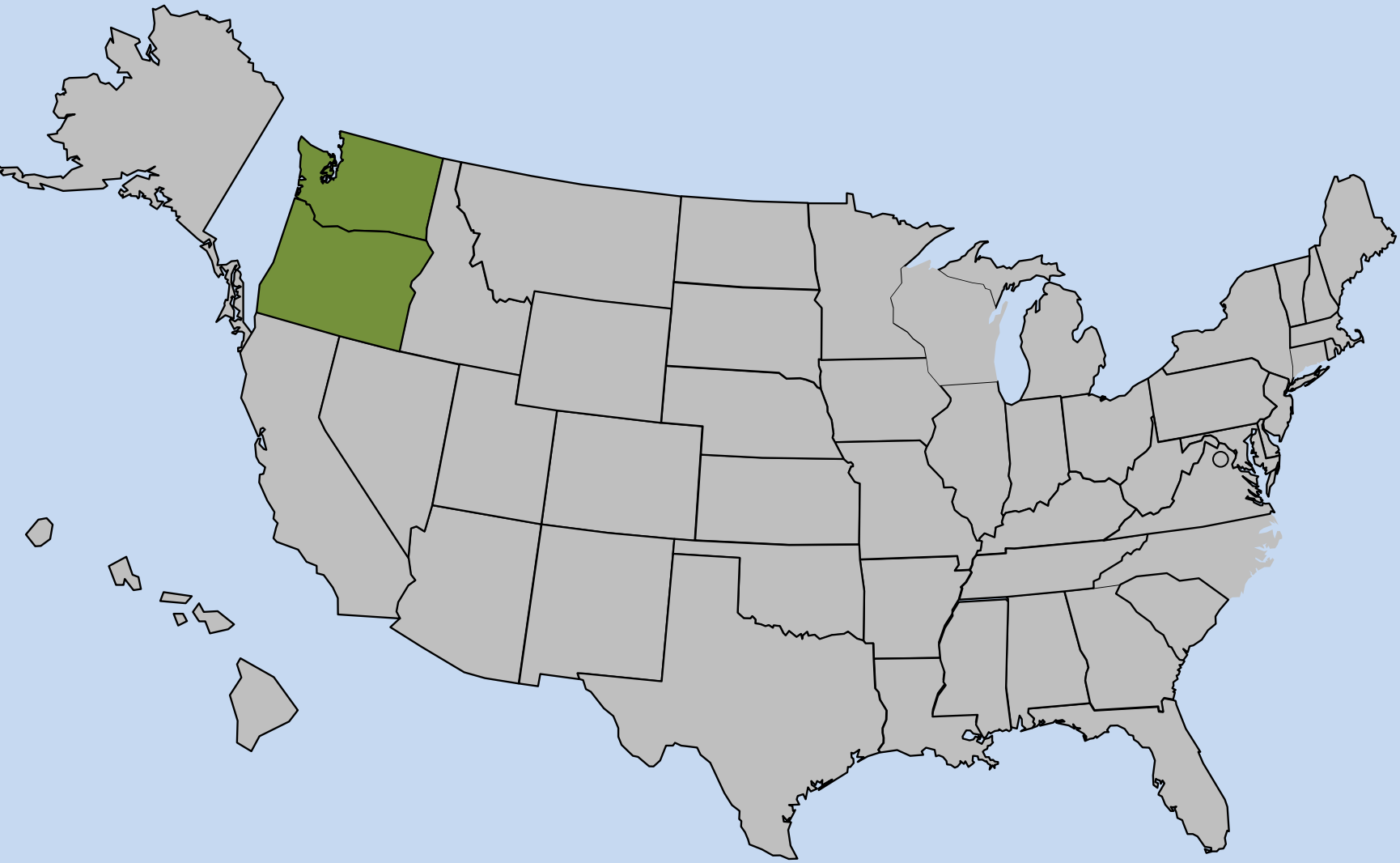
72% gone to college

2008

Washington

Ballot initiative

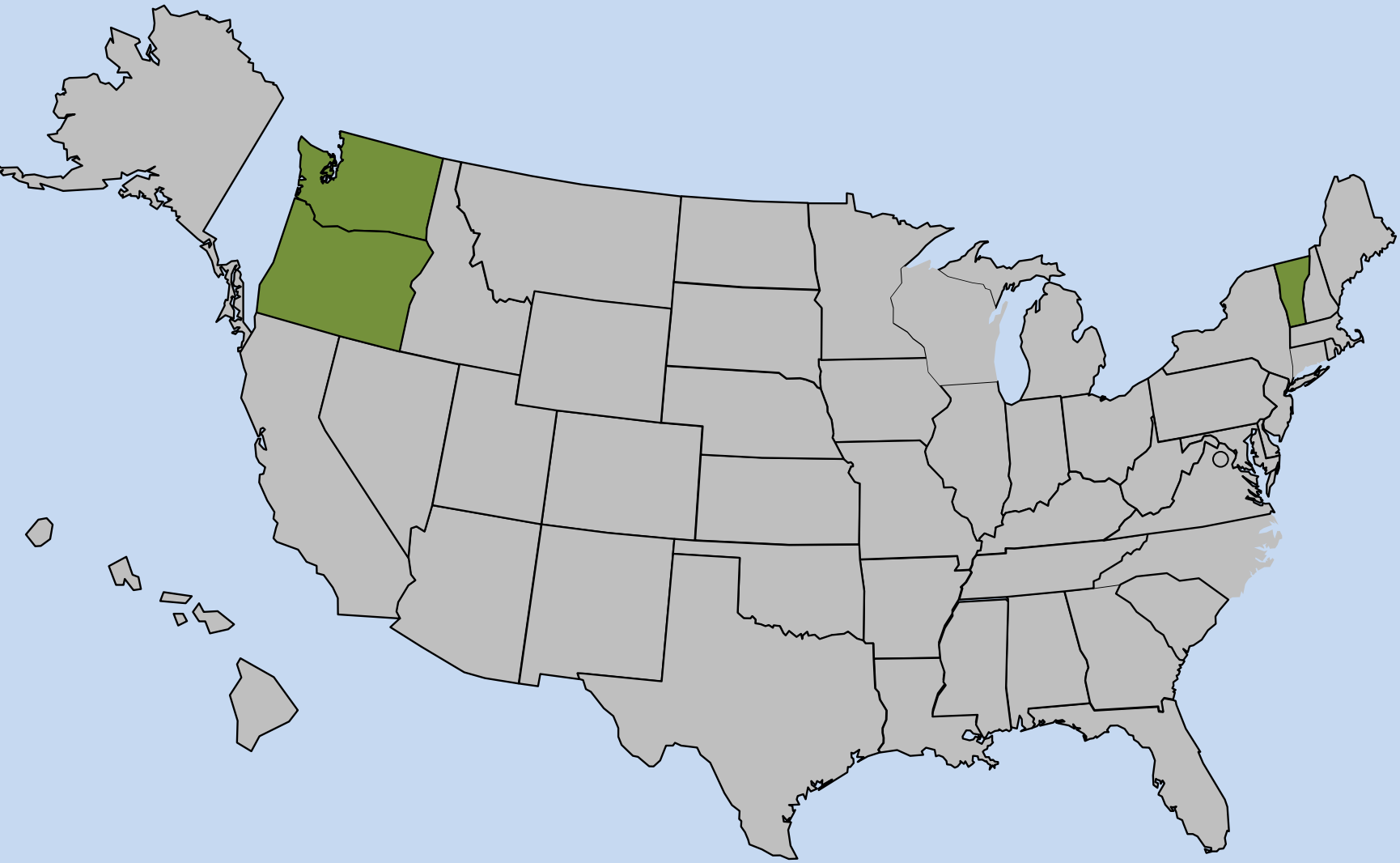
58%



May 2013

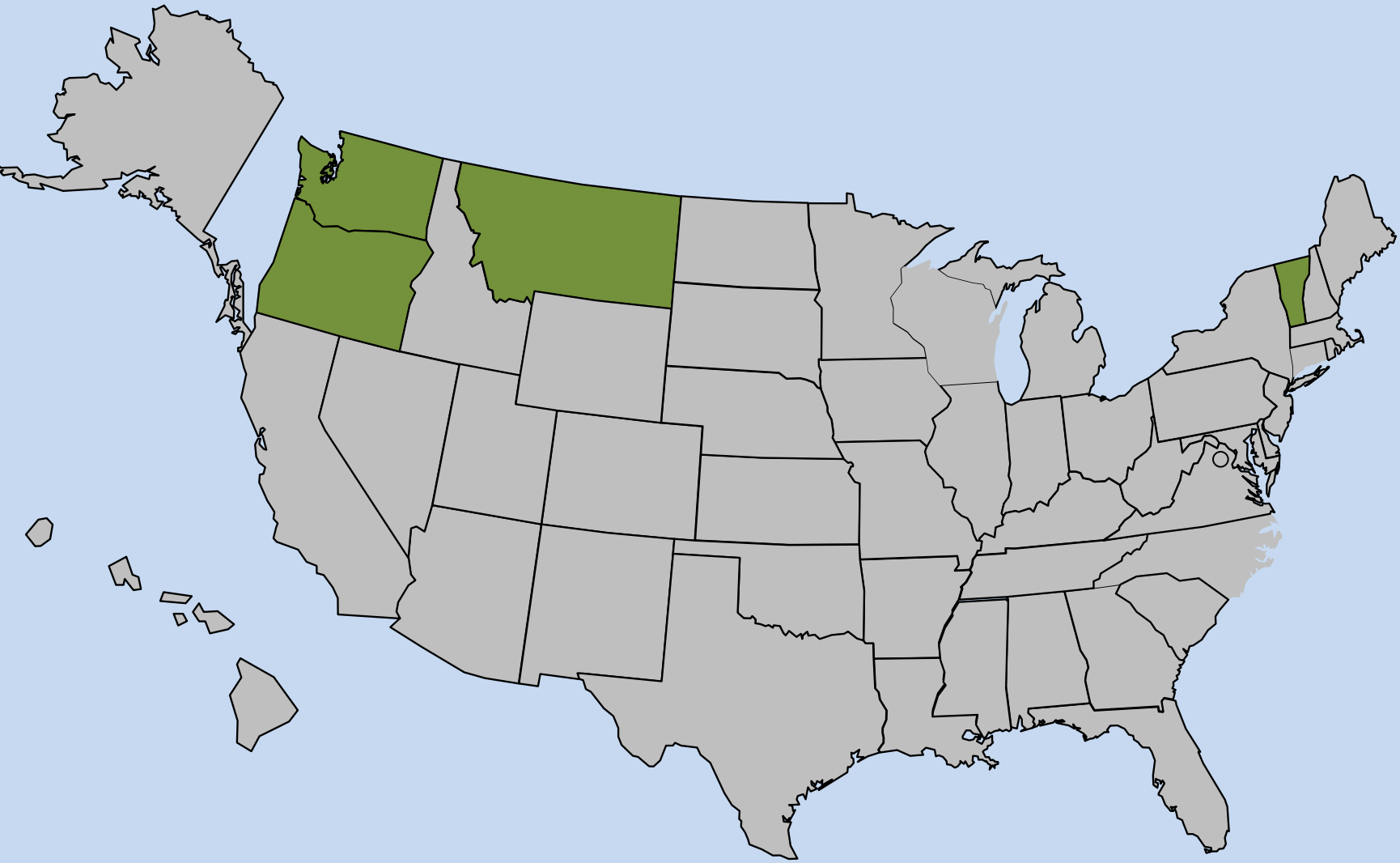
Vermont

Legislation instead of ballot initiative



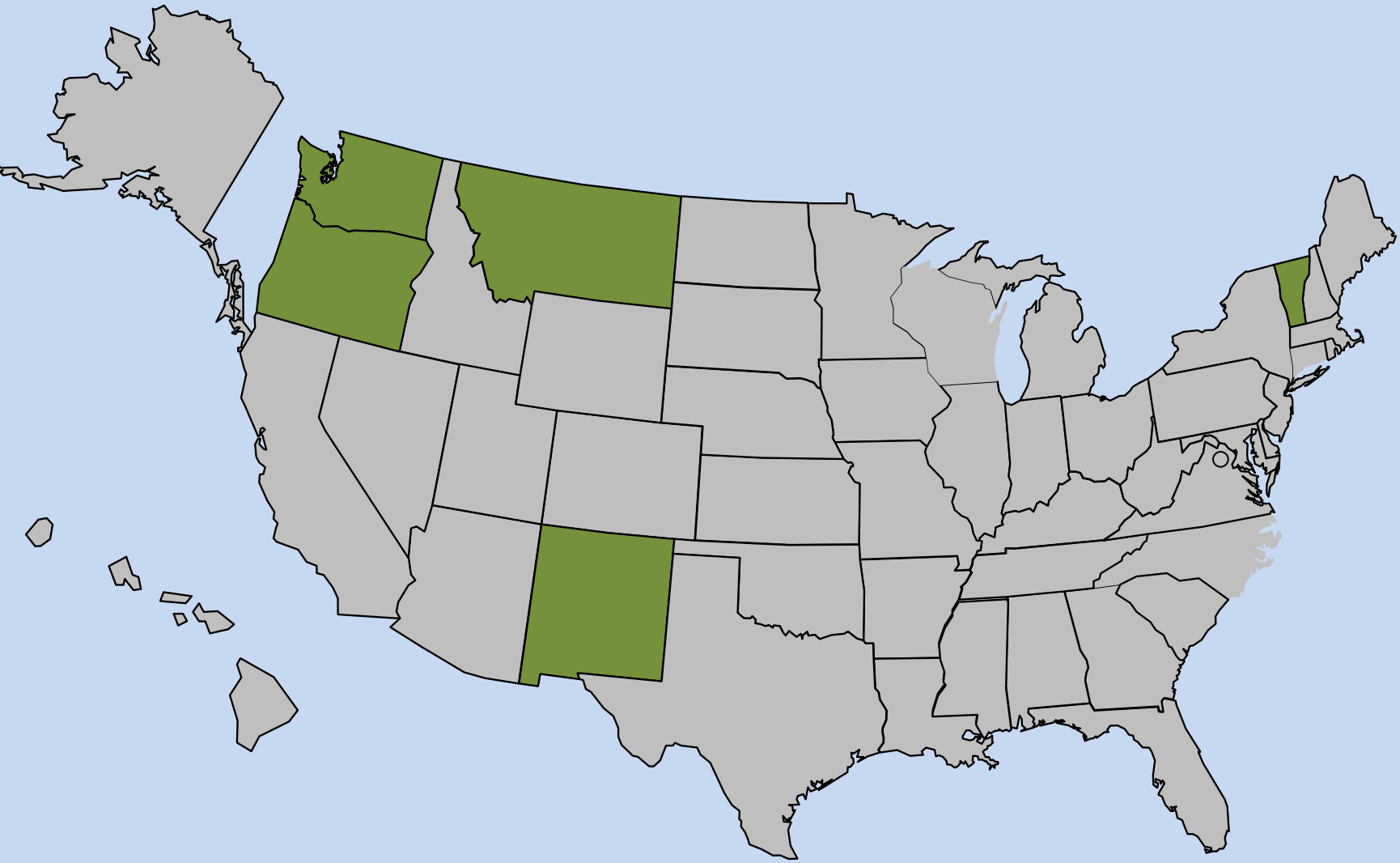
Dec. 2009

Montana via court decision



Jan. 2014

New Mexico via court decision



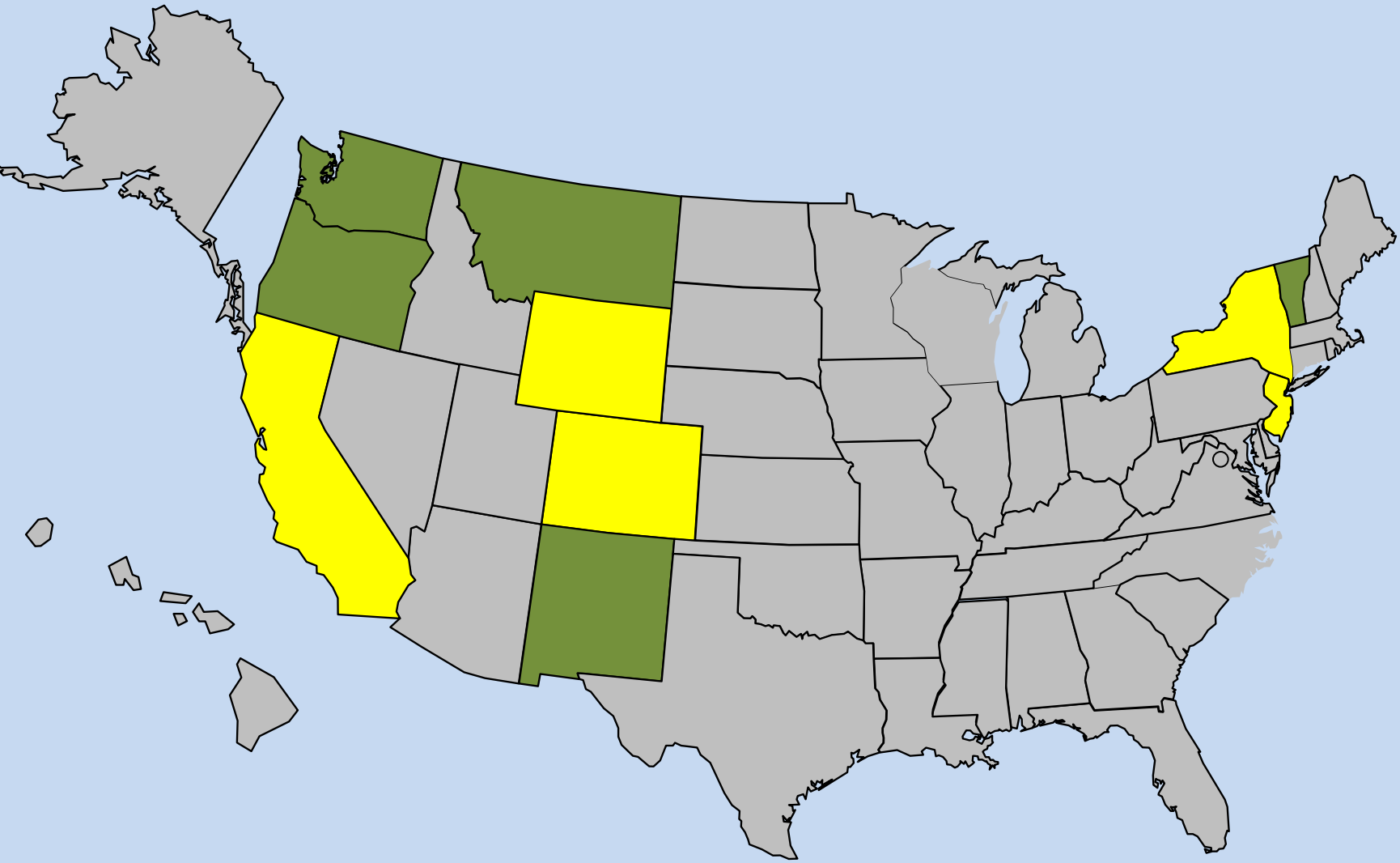
June 2014

Quebec


Yukon Territory
Northwest Territories
Nunavut
British Columbia
Alberta
Saska-tchewan
Manitoba
Ontario
Québec
Labrador
Newfoundland
P.E.I.
New Brunswick
Nova Scotia

February 2015

Activity in the states



Other exit options

In order of acceptability

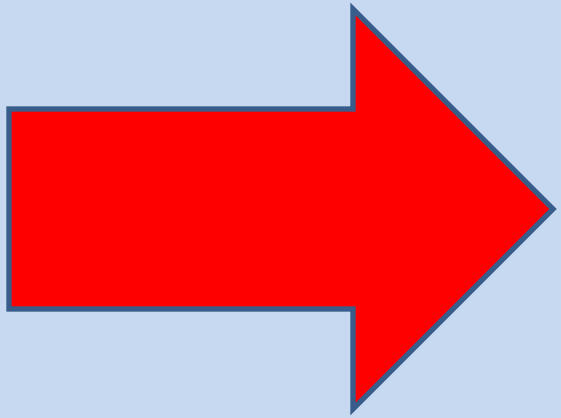
Stop LSMT **okay**

AID – PAD **5 states**

Euthanasia **illegal**

In order of acceptability

Stop LSMT



AID – PAD

Euthanasia

High dose Opioids


NDC 0409-1134-02
Single-dosage Fliptop Vial
MORPHINE
CII
Sulfate Inj., USP
Rx only
(50 mg/mL)*
1000 mg*
1000 mg*
WARNING: MAY BE HABIT FORMING.
CAUTION: FOR DILUTION ONLY.
NOT FOR DIRECT INJECTION.
Hospira

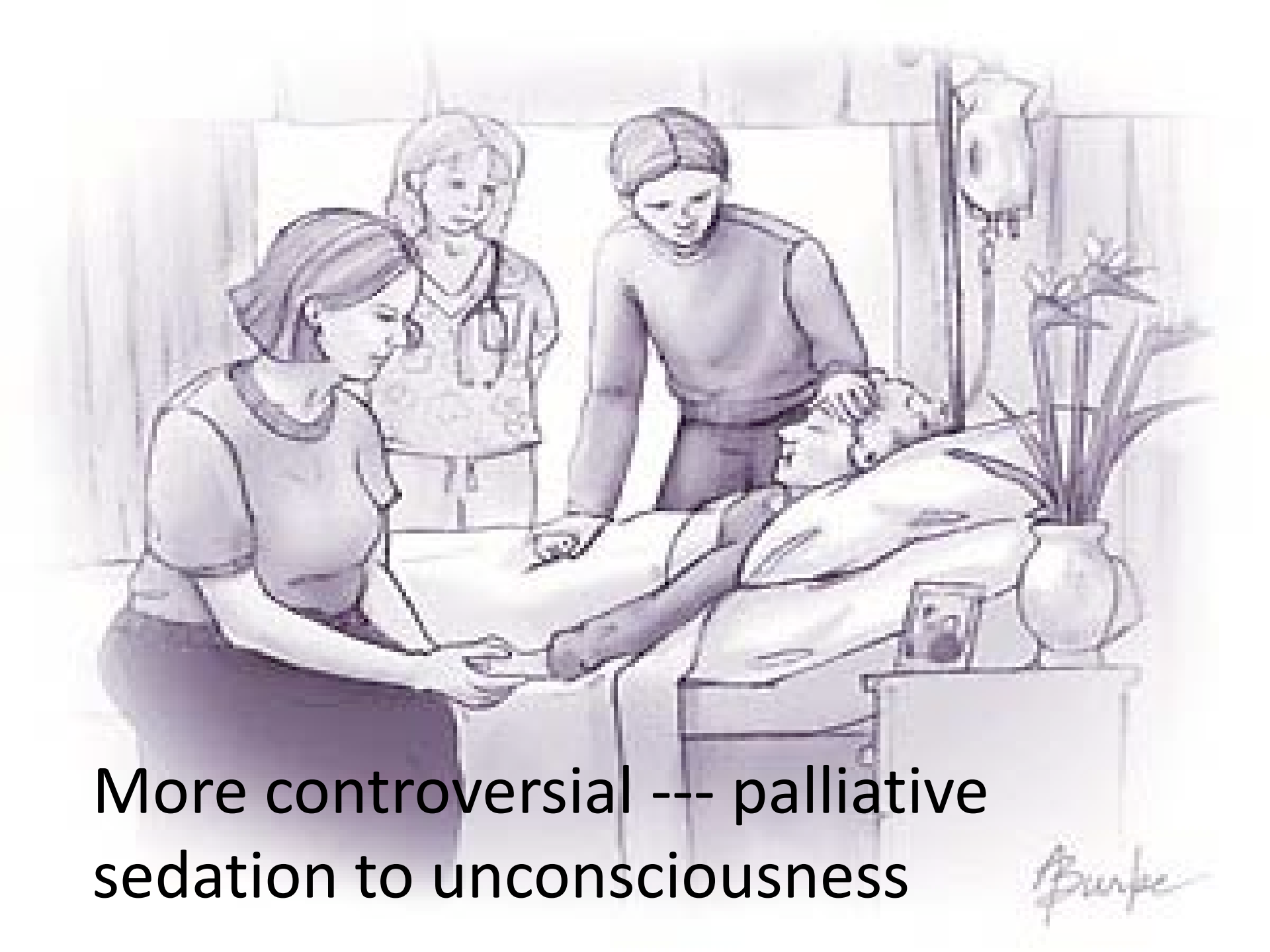
Mostly accepted

Risks respiratory depression and death

Double Effect

1. Action good in itself (not immoral)
2. Intend the good effect (foresee but not intend bad effect)
3. Bad effect not necessary for good effect
4. Proportionality (sufficiently grave reason to risk bad effect)

PSU



More controversial --- palliative sedation to unconsciousness

	Palliative Sedation	Euthanasia
Intent	Sedate	Kill
Process	Administer drug doses, titrated to effect	Administer lethal drug dose
Outcome	Decreased consciousness	Death

PSU makes Pt **dependent** on CANH

Typically Pt **refuses** CANH

$$
\begin{array}{r}
1 \\
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= 3
\end{array}
$$

VSED

Find existence intolerable

Nothing to turn off

Dehydrate = death 10-14 days

Generally accepted, if patient decides herself


Controversial to make
advance decision

VAE

IVAE

Voluntary active **euthanasia**: doctor administers lethal agent

Illegal everywhere in North America

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